Spring 2009

Working Toward Recovery: Exploring the Development of an Employment Services Program at the Mental Health Association of the Southern Tier

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WORKING TOWARD RECOVERY: EXPLORING THE DEVELOPMENT OF AN EMPLOYMENT SERVICES PROGRAM AT THE MENTAL HEALTH ASSOCIATION OF THE SOUTHERN TIER

BY

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CAPSTONE PROJECT

Submitted in partial fulfillment of the requirements for
the degree of Masters in Public Administration in the Graduate School of
Binghamton University
State University of New York
2009

Accepted in partial fulfillment of the requirements for
the degree of Masters in Public Administration
in the Graduate School of
Binghamton University
State University of New York
2009

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Abstract

The almost complete exclusion of individuals with severe mental illness from the workforce can be implicated in lost recovery opportunities and high societal healthcare costs. This study initially looks at how the motivational theories of Herzberg, Maslow, and McGregor offer a possible explanation for the problems that individuals with mental illness have in obtaining and maintaining employment. The analysis of results of a survey conducted in conjunction with the Mental Health Association of the Southern Tier led to the following findings: 1) the theories of Herzberg, Maslow, and McGregor explain the employment attitudes of these individuals without amendment; 2) employment attitudes are largely independent of the intensity of mental health services that consumers receive; 3) common demographic categories do not determine employment attitudes or work interests in a significant way; and 4) most consumers of mental health services want to work and believe they have the skills necessary to be successful in the workplace.

Dedication

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Professionals and laypeople alike are realizing in increasing numbers that mental health is an integral component of general wellbeing. As this realization occurs, it becomes apparent that much of the nation's population is experiencing mental health difficulties. Some broad categories of mental illness, such as personality disorders and anxiety disorders, are potentially affecting more than 10 percent of the general population over the course of a 12-month time period (Baumeister & Härter, 2007).

While no mental aberration should be dismissed as trivial, some diagnoses are recognized as more serious than others. "Serious mental illness" affects about 2.6 percent of individuals in the United States (Larson, Barr, Corrigan, Kuwabara, Boyle, & Glenn, 2007). The long term consequence of not attending to serious mental illness is often psychiatric disability. Of course, some individuals with a serious mental health diagnosis maintain high levels of functionality by using medication, participating in psychotherapy, and taking care of their mental health in other ways.

The Mental Health Association of the Southern Tier (MHAST) has been working since 1927 to address the mental health needs of the local community. Today, the organization and its approximately 30 employees are primarily dedicated to serving the residents of New York's Broome County. MHAST offers services geared toward the mental health needs of children, families, and adults who are dealing with mental illness or related issues. It also offers educational, self-help, chemical dependency, and diversity-based programs. Most consumer services are provided without cost to the client, which establishes MHAST as one of the community's last means of recourse in mental health emergencies. In fact, program and service fees accounted for only about one percent of the agency's revenue in 2007. Like many nonprofit organizations, MHAST relies on government support for much of its funding. In 2007, the New

York State Office of Mental Health provided the agency with $669,744, or 35.5 percent of its revenue. The yearly assistance received from the New York State Office of Mental Health has increased by about $200,000 since 2005. The United Way is the second largest provider of funds to the Mental Health Association of the Southern Tier and contributes around $110,000 annually. Generous community businesses and charitable citizens that are dedicated to advancing health and well-being provide the organization with an additional $100,000 each year. MHAST's average annual budget is just under $1,000,000, although it doubled in 2006 and 2007 as the agency participated in the Project Recovery program to assist the region with flood relief and recovery efforts. The agency budgets over $100,000 annually for each of the three programs whose participants took part in this study.

It may be difficult for those who have no direct connection to someone diagnosed with serious mental illness to understand the psychological turmoil that these conditions cause, but they may appreciate the financial implications. More than 70 percent of the individuals who have been disabled by severe mental illness live in poverty and receive their only income from Social Security assistance programs (Larson et al., 2007). The drastic difference between barely making ends meets while receiving a few hundred dollars each month in government entitlements and living in relative comfort while earning thousands of dollars during a similar period with an average job underscores both the severity of many mental illnesses and the barriers that individuals with mental illness face when attempting to work. While the direct costs of providing mental health-related disability incomes to at least 1.82 percent of the country's population undoubtedly weighs on public coffers, a realistic view of the situation must acknowledge that much greater benefits are forgone through the nearly categorical exclusion of individuals with serious mental illness from the workforce.

The high percentage of unemployment among individuals with severe and persistent mental illness has been thoroughly documented at the macroscopic level. Current studies place the rate of unemployment among this group at between 85 percent and 90 percent (Larson et al., 2007). This figure leads one to wonder if individuals with mental illness simply lack the motivation and desire to work or if there are but few employment opportunities for these individuals. Examining the motivation of individuals with mental illness to work is a primary purpose of this project.

Public attitudes about mental illness, the individuals it affects, and the intersection of these two factors with employment are largely out-of-date. Reconciling the traditional caricature of the mentally ill individual with the image of the conscientious or even ambitious employee or manager is exceedingly difficult for the general public, and there are no highly visible programs that encourage people to think about mental illness in different terms. Employed individuals who develop psychiatric issues and seek help may not be automatically subjected to career-crippling stigma, but it is still necessary for many to hide their problems (Corrigan, 2004) if they desire to retain a respected spot in the American workplace or avail themselves of opportunities to ascend the organizational ladder.

The incompatibility that the public perceives between mental illness and employment are not mirrored in the realm of psychiatry: many mental health professionals argue that productive activity both facilitates recovery from mental illness and plays an essential role in helping all people achieve optimal levels of health (Blustein, 2008). By not making earnest efforts to connect mentally ill individuals with dignified careers, society is robbing itself of an opportunity to actively reduce the negative effects of mental illness on both those afflicted by it and those who bear the cost of treatment (Larson et al., 2007). At the same time, the benefits of the

creativity, industriousness, and dedication that individuals with mental illness could apply to corporate, charitable, and governmental ventures are foregone. Since the loss of a job is often the catalyst for mental health deterioration (Blustein, 2008), the development of truly intelligent societal labor policies will involve both bringing individuals with mental illness into the workplace and making terminations of "healthy" workers as rare as possible.

Problem Definition

MHAST would like to increase its ability to assist individuals with mental illness who are located in this region with finding and maintaining employment. The agency is inclined to pursue this direction because it witnesses on a daily basis the effects of the rampant unemployment and underemployment of individuals with mental illness. Without employment and the health benefits that accompany it, consumers are less able to control the course of their lives. In many cases, individuals without employment must rely on government and nonprofit organizations for assistance with their mental health needs. These systems are currently under financial stress (Larson et al., 2007), which makes them less able to provide the services that consumers (as individuals seeking mental health services prefer to be known) need. Individuals who are unable to get help with their mental health needs often become homeless and destitute, two conditions that befall individuals with mental illness in disproportionate numbers (Rossi, 1990). MHAST and its personnel can attest that these trends regarding mental illness, homelessness, and destitution do not spare the Southern Tier of New York.

MHAST also recognizes that employment is often central to an individual's perception of self-worth, an idea supported by the research of Larson et al. (2007). Self-worth and self-esteem are of central importance to overall mental health, and MHAST is committed to facilitating growth in these two areas in all people. As an individual's self-esteem increases, it becomes

easier to weather adverse situations and regulate moods (Blankertz, 2001). These two conditions are the basis of mental resilience. When a person becomes mentally resilient, they are able to remain in a state of equilibrium as moderately undesirable occurrences beset them internally and externally (Van Vliet, 2008). High self-esteem and fortified mental resilience help individuals to deal with potential problems without turning to negative or unhealthy coping strategies. Thus, individuals with mental illness who have high levels of self-worth, self-esteem, and resiliency will be able to navigate the path toward recovery more effectively those who lack these traits. Those with low levels of self-esteem often have trouble becoming motivated to change for the better (Blankertz, 2001).

The Mental Health Association of the Southern Tier and its staff are dedicated to not only counteracting the negative effects of stigma that individuals with mental illness face, but also removing such hostile sentiments from the community at large. Increasing employment among individuals with mental illness is an important component of this goal, since it will increase the public visibility of this group in a manner that showcases their willingness to contribute to the economic and civic success of the community. MHAST is directed by its mission statement "to advocate, educate, and support" as it attempts to perpetuate the visibility and comfortableness of individuals with mental illness as they engage in productive life activities in manners similar to that of the population without mental health diagnoses. If individuals with mental illness receive the support and advocacy that they need and the public is in turn educated about the true nature and potential of individuals with mental illness, these two subsets of the overall population will hopefully realize that the similarities they share greatly overshadow any differences. Ideally, sustained progress in this direction would lead the commonly-held view that those with mental illness are intrinsically different from the "normal" population to be soundly rejected. Branching

out into employment-related services would allow MHAST to enhance its commitment to all three components of its mission statement.

If MHAST is to begin offering employment-related services, the organization wants to do it in a manner that is as effective as possible. The most innovative and recently developed form of supported employment, Individual Placement and Support, results in a job for just over 50 percent of participants under ideal conditions (Larson et al., 2007; Loveland, Driscoll, & Boyle, 2007). Other forms of supported employment have less impressive records, and many individuals who find a job through any type of supported employment are unable to retain their job for a length of time that is indicative of true success. Of course, many individuals with mental illness prefer to obtain jobs without ongoing support from an outside program.

Although it is unreasonable to expect to enter the workforce in something other than an entry level position if one does not have substantial work experience and training, it should be possible for an individual with mental illness to obtain a job they genuinely want to do and that will afford them a level of dignity they are satisfied with. There is a difference between generally wanting to work, which is usually one criterion for participation in supported employment (Loveland, Driscoll, & Boyle, 2007) and wanting to work at a specific job. Thus, typical supported employment programs that focus on rapid job placement and offer unlimited support may perpetuate the idea that individuals with mental illness are somehow less capable than others because they inadvertently cause participants to set their employment goals low.

MHAST does not want to run a typical supported employment program. Consumers who take advantage of MHAST's services are very diverse in terms of diagnoses, severity of symptoms, levels of functionality, and life situations. Although there may be some aspects of an employment services program that are appropriate and necessary for the vast majority of

consumers, MHAST wants to tailor its services to the individual needs and aspirations of each consumer it assists. This means providing the resources to help them find and obtain the jobs they want, not just the ones that are available. It is likely that consumers will request assistance with obtaining jobs in settings ranging from sheltered employment to non-supported professional employment. The job search and application process may take longer as a result in some cases, but it will hopefully end in more successful placements and less attrition because the consumers will end up in jobs they are truly interested in performing.

It is assumed that the people who best know what services they want in an employment services program are the ones who will actually be using it. If MHAST continues its tradition of non-paternalistic treatment of individuals with mental illness and actively seeks the input of consumers in the planning of this program, it will likely differ from existing supported employment programs in both its palatability and levels of success. This research contributes to the planning and design process for MHAST by gathering and analyzing information from the intended users of an employment services program.

Research Question

How can the Mental Health Association of the Southern Tier best develop an employment services program that effectively meets the needs of its client population?

Conceptual Framework

The interactions between individuals with mental illness and the workplace can be partially understood through the examination and creative applications of various motivation theories. Maslow's Theory of Human Motivation, Herzberg's Motivation-Hygiene Theory, and McGregor's framing of "Theory X" and "Theory Y" can be combined with synergistic potential to create a macroscopic and multifaceted explanation of the work habits of individuals with

mental illness. Each is also useful on its own for explaining certain aspects of various subpopulations' levels of engagement with the job market. In addition to this, these motivation theories can be used to understand the social control elements that often keep individuals with mental illness out of work.

Literature Review

Human motivation has captivated scientists for many centuries. In the realm of business and industry, employee motivation has been an established area of inquiry since the early 1900s (Wilkinson, Orth, & Benfari, 1986). The questions that Frederick Taylor asked at that time, such as what disposition best suits a worker to a task, have only increased in complexity as occupations have become more diverse. Whereas Taylor searched for insights into motivation at the level of the worker, the scope of the inquiry now takes the entire organization into account (Blustein, 2008). Thus, what started out as industrial psychology has evolved into industrial/organizational psychology.

Scholars have long been attempting to provide managers with the information they need to maintain employee satisfaction, organizational health, and industry productivity (Blustein, 2008). However, the answers that satisfied one generation of managers have typically fallen short of the needs and expectations of subsequent managerial generations. Perhaps this is because the productivity of the average worker has a finite limit and the change in worker productivity over time is quite linear. Workplace technology, on the other hand, advances in a more exponential fashion, leading to an ever-increasing discrepancy between actual workplace output and hypothetical workplace output.

Although this process has been through several iterations since the birth of industrial/organizational psychology, the ideas that have been advanced have not always been

new. Barring the work of Maslow, most of the development in motivational theories occurred during the 1960s and 1970s (Bassett-Jones & Lloyd, 2005). The giants of this time were Herzberg and McGregor, and their ideas continue to appear among "new" theories, albeit in slightly reformulated terms (Whittington & Evans, 2005). Some authors even assert that the theories of Herzberg and McGregor are just applications of Maslow's Human Needs Hierarchy in specific industrial settings (Wilkinson, Orth, & Benfari, 1986). If influence on later scholars is any indication of the greatness of an idea, the theories of Maslow, Herzberg, and McGregor easily withstand the test of time (Whittington & Evans, 2005).

I suggest that the interactions between individuals with severe mental illness and the realm of employment, whether it be full engagement, temporary engagement with an unsuccessful outcome, or non-engagement, can be partially explained through the innovative application of the motivation theories of Maslow, Herzberg, and McGregor. Without a large amount of previous scholarship to serve as a guide, this project's author had the unique opportunity to advance connections between the work of the aforementioned theorists and the life situations of individuals with mental illness. To show that these advances are grounded in solid scholarship, the motivational theories in question will be elucidated in their original context. After this has been done, they can be applied to areas that their originators did not consciously develop them for. Before that, however, the population to which these theories are to be applied needs to be understood if the discourse is to be meaningful.

Mental Illness in the United States: A Brief History

One of the great ironies of the latter half of the 20th century is that mental illness, as a concept, was essentially lobotomized. On the surface of society, it became accepted that "mental illness" was not limited to individuals who were psychotic. The first edition of the American

Psychological Association's Diagnostic and Statistical Manual of Mental Disorders, which was published in 1952, included categories that medicalized what were formerly considered bad habits and bad temperaments (Starks & Braslow, 2005). Once these less severe mental conditions had been officially inducted into the ranks of accepted disease, attitudes about seeking treatment for them became more liberal as the years passed. This has been aided by vast investments in new medications and the proliferation of the conditions themselves. By the start of the third millennium, some cases of anxiety, obsessive-compulsive disorder, depression and other disorders had become thoroughly treatable with the right combination of medication and psychotherapy.

While situations improved for people with mild mental illness, individuals with more serious forms of mental illness were met with promising developments that were not utilized to their full potential. True optimism surrounded the development of antipsychotic medications in the 1950s (Lamb, 2001; Rivas-Vazquez, Blais, Rey, & Rivas-Vazquez, 2000; Starks & Braslow, 2005), but a treatment system for mental illness cannot be built on drugs alone. Most inpatient psychiatrists used early antipsychotic medications as a way to calm patients and control their behavior. The philosophy that behavior was the only manifestation of disease that could be "treated" in individuals with severe mental illness meant that psychotherapy was largely forgone even when patients had been substantially calmed (Starks & Braslow, 2005). Thus, the initial mass distribution of antipsychotics did nothing more than increase the docility of the institutionalized population.

It cannot be denied that the early antipsychotics were an improvement over options like lobotomy and heavy sedation, but these substances were not universally effective "miracle cures." Many patients' symptoms could withstand heavy doses without showing substantial

signs of improvement. If used improperly, antipsychotic drugs could destroy a patient's physical health. Weight gain, neurological problems, and sedation often accompanied treatment (Rivas-Vazquez et al., 2000). When coupled with the mental sluggishness that the medications induced, some patients felt that the "cure" was just as unpleasant as their disease.

The cost and conditions of the country's extensive system of psychiatric institutions came under scrutiny in the late 1950s and early 1960s (Lamb & Weinberger, 2001; Mental illness, 2008). Many healthcare professionals alleged that conditions in institutions actively harmed their residents, which gave credence to the emerging belief that the mentally ill did not need to be isolated from the rest of society (Mental illness, 2008).

The answer to both the cost and performance "problems" of the country's mental health system was "deinstitutionalization." Shifting patients out of institutions and into community-based care settings would supposedly lead to better lives for the mentally ill (Mental illness, 2008) and lower costs for the government and taxpayers. As a complex social operation, deinstitutionalization cannot be classified as a complete success or a complete failure. The emphasis on community care for individuals with mental illness has become paradigmatic and likely serves the needs of certain individuals very well in its present form. Autonomy and independence, even if they are somewhat qualified, are valuable to many individuals with mental illness. However, one cannot ignore the drastic funding cuts and service gaps that initially left large segments of the population without care (Mental illness, 2008). The network of group homes needed to accommodate the institutionalized population was not adequately developed before institutions reduced their capacity, which in turn led to increased homelessness for these individuals. Pressures to reduce the cost of government-provided mental healthcare have

chipped away at services and left many individuals with mental health issues without sufficient support (Mental illness, 2008).

Consumers who depend on government funding to meet their mental health needs occupy a precarious societal position. Without a strong voice in government, individuals with mental illness have been forced to accept significant budget cuts to the programs they value as other taxpayers and their representatives develop different priorities on financial issues. However, groups like the National Alliance for the Mentally Ill (NAMI) and related organizations bring individuals with an interest in the health of this population together to advocate for progressive improvements in both fiscal and social policy (Mental illness, 2008).

The virtual disappearance of mental institutions and the reduced funding given for mental health programs scaled back the visibility of serious mental illness in society. With only events like the planned construction of a group home in a neighborhood or the sighting of large numbers of mentally distressed people in a community's downtown district bringing the issue to the public's attention, it is almost possible to forget that serious mental illness still exists. Even though accurate information about mental illness is available, sensational claims can easily taint discussions about the people it affects and their living conditions. As with other conditions and lifestyles, individuals with serious mental illness will be consigned to second-class citizenship until society as a whole becomes convinced that dignified coexistence is possible.

Theories of Motivation

Although several types of motivation theories exist, this project is particularly conducive to the examination of theories that address work or personal growth in the context of individual needs, environmental comfort, or personal relations. For this reason, the theories of Maslow, Herzberg, and McGregor will be examined in further detail.

Maslow's Theory of Human Motivation.

Maslow (1943; Maslow, 1987; Ramlall, 2004; Stretton, 1994; Whittington & Evans, 2005; Wilkinson, Orth, & Befari, 1986) postulated that human needs and the motivation to satisfy them emerge in a predictable and hierarchical manner. This hierarchy of needs is often illustrated as a five-tiered pyramid in which the lower order needs occupy the bottom levels and the higher order needs are ascribed to the upper levels. The pyramid illustration is also useful as a representation of the proportion of the population that is able to meet each need. For example, all humans that remain alive satisfy their physiological needs, but not all of these are able to satisfactorily meet the next higher need of safety.

Physiological (such as sleep and food requirements) and safety needs are the basest human needs (Maslow, 1943; Maslow, 1987; Stretton, 1994). In turn, they are the most potent motivators. Substantial energy and thought cannot be directed toward the satiation of other concerns before both of these first two tiers of needs are properly addressed.

The middle or third level of Maslow's (1943; Maslow, 1987; Stretton, 1994) hierarchy encompasses the need for love. "Love" is meant in a generic sense; camaraderie, friendship, and belonging address the same basic need. This love need is followed by the esteem need, which has both personal and social components. Esteem needs can be met through the mastery of different tasks, duties, and skills. Maslow's (1943; Maslow, 1987; Stretton, 1994) highest need is that of self-actualization, or the realization of one's highest potential. It is stated that "What a man *can* be, he *must* be" (Maslow, 1943, p. 382, italics in original). However, with its location atop the hierarchy, many people fall short of this need. By Maslow's own admission, the lack of self-actualized people was so great that it prevented him from studying this state in great detail.

When discussing the emergence of needs and the motivation to satiate them, Maslow (1943) acknowledged that various needs could be present at the same time but in varied strengths. Some contemporary scholars (Goodman, 1968; Whittington & Evans, 2005; Wilkinson, Orth, & Benfari, 1986) have deduced from Maslow's numerous theoretical iterations that all needs are present at all times and that the one or more that manifest themselves at any time are determined by the situation.

Maslow was not an industrial/organizational psychologist and he did not develop his theory with the workplace specifically in mind. While this should not lessen its applicability to actual or potential employees, it means that all scholarship in this area has been carried out by other individuals. On the whole, scholars have been very receptive to Maslow's ideas and their research has mostly reinforced his theory.

Herzberg's Motivation-Hygiene Theory.

Herzberg's Motivation-Hygiene Theory (which is also known as two-factor theory) was most famously advanced in his 1968 article entitled "One more time: How do you motivate employees?" with his analogy of "KITA," or in less polite terms, a "kick in the ass." However, the theory had been previously advanced in Herzberg's 1959 publication with Mausner and Snydermann. While discussing the KITA analogy is entertaining, the larger point is that both negative KITA and positive KITA fail to motivate employees. Instead, they merely cause them to move or act in accordance with the manager's wishes (Herzberg, 1968; Bassett-Jones & Lloyd, 2005). Despite the compliance that results from KITA, it is exhausting to the manager's psyche and the organization's resources because they must be continually dangling rewards before their employees, ordering them to do a task in a not-so-polite fashion, or trying to

manipulate them with a number of management fads that Herzberg (1968) categorically dismisses.

The solution to this problem is to make employees want to perform their duties (Herzberg, 1968). A desire to work is compared to an internal generator that is capable of charging an employee's battery without the need for continual recharges (which invariably take the form of KITA). The revolutionary aspect of Herzberg's two-factor theory is that it not only classifies these continual recharges as undesirable but also asserts that they are unsustainable. Increasing wages cannot endlessly prop up an employee's willingness to complete a task (Bassett-Jones & Lloyd, 2005). Instead, there must be an intrinsic desire to do so (Ramlall, 2004).

Factors that enhance an employee's desire to work by heightening the intrinsic rewards that the job gives them are "motivators," while the factors that merely make work tolerable are "hygiene" elements (Herzberg, 1968; Herzberg, Mausner, & Snyderman, 1959). Motivators (such as achievement, recognition, responsibility, advancement, and growth) are found in a job's content and lead directly to feelings of satisfaction (Bassett-Jones & Lloyd, 2005; Herzberg, 1968; Herzberg, Mausner, & Snyderman, 1959; Hines, 1973; Ramlall, 2004; Whittington & Evans, 2005; Wilkinson, Orth & Benfari, 1986). A lack of motivators does not produce job dissatisfaction, but instead results in a state of no job satisfaction. Job dissatisfaction arises when hygiene elements are not sufficient and working becomes physically or mentally uncomfortable. If hygiene factors (such as company policy and administration, supervision, workplace relationships, work conditions, salary, status, and security) are adequate, employees will experience no job dissatisfaction. Therefore, the decision to remain in a job is based on the

continuous assessment of the balance of motivators and hygiene elements. However, it is important to realize that motivators and hygiene elements operate on two separate axes.

One promising way to increase the motivators that an employee perceives is through "job enrichment" (Herzberg, 1968). Managers enrich jobs by "vertically loading" responsibilities and the recognition that goes with them (Herberg, 1968; Herzberg, 1979; Ramlall, 2004). When job enrichment goes wrong, the result is job enlargement. This is the "horizontal loading" of additional but meaningless tasks.

McGregor's Theory X and Theory Y.

McGregor's concept of Theory X management and Theory Y management is the dichotomization of the two most fundamental management philosophies in existence. Theory X is the philosophy that humans dislike work and want to avoid it (McGregor, 1960; Whittington & Evans, 2005; Wilkinson, Orth, & Benfari, 1986). Managers operating from this level think that getting a human to engage in productive activity requires manipulation and the giving of direction. Theory X also asserts that workers are thought to most desire situational security and do not want to be faced with responsibility. Theory X is an example of a "classical" management philosophy (Wilkinson, Orth, & Benfari, 1986).

Theory Y is a very different type of management philosophy. According to Theory Y, work is a natural human activity designed to satisfy needs (McGregor, 1960; Whittington & Evans, 2005; Wilkinson, Orth, & Benfari, 1986). As such, workers exercise self direction and self control when they are committed to both the task at hand and the reward that its completion will bring. Since work only engages a limited portion of a person's mental capacity, workers desire to participate in work-related decisions. Theory Y is considered a "participative" management strategy (Wilkinson, Orth, & Benfari, 1986).

No civilian workplace uses a pure version of either of these theories. Instead, the balance is shifted more toward one of these theories. Higher concentrations of Theory X management are useful when the organization in question is "more formalized and controlling" (Wilkinson, Orth, & Benfari, 1986, p. 26; Whittington & Evans, 2005). Managerial schemes skewed toward Theory Y facilitate productivity best in "less formalized and controlling" organizations (Wilkinson, Orth, & Benfari, 1986, p. 26; Whittington & Evans, 2005).

The relationship between Herzberg, Maslow, and McGregor.

Wilkinson, Orth, and Benfari (1986) assert that the theories of Herzberg, Maslow, and McGregor are very compatible, but their original phrasings are designed for different types of situations. This scholarship undoubtedly springs from McGregor's (1960) use of Maslow and Herzberg's ideas in describing the practical implications of Theory X and Theory Y. In what can be called the "basic management scheme," Wilkinson, Orth, and Benfari (1986) reconcile the three theories in the following way. The physiological and safety needs of Maslow's hierarchy translate roughly to Herzberg's hygiene elements. McGregor's Theory X management focuses itself more on the satisfaction and control of these hygiene elements to the exclusion of Herzberg's motivators and Maslow's higher order needs.

The "advanced management scheme" is crafted by Wilkinson, Orth, and Benfari (1986) in a similar fashion, except it focuses on the higher aspects of the theories of Herzberg, Maslow, and McGregor. Maslow's higher order needs (love, esteem, and self-actualization) correspond to Herzberg's motivators. These motivators are then facilitated by management styles in line with McGregor's Theory Y.

Applying Motivational Theories to the Employment of Individuals with Mental Illness

Due to the lack of previous scholarship in the area of motivational theories and their general intersection with individuals affected by mental illness, the following sections contain what the author believes to be logical applications of the work of Maslow, Herzberg, and McGregor to the work behaviors of individuals with mental illness. It should be recognized that this scholarship is based in both theory and the documented work experiences of much of the population in question, but it remains untested at this point.

An exacerbation of Maslow's safety needs.

When discussing the safety need, Maslow (1943) asserted that modern, peaceful societies easily supply the most basic forms of safety. To see an unsatisfied level of safety in action, he suggested observing infants and individuals who were "neurotic." Maslow (1943; 1987) noted that "compulsive-obsessives" attempted to organize their world so that nothing unexpected would ever happen and they could be assured of safety. If this point is extrapolated to its logical conclusion and phrased slightly differently, it becomes apparent that individuals with mental illness often have greater safety concerns than the general population.

While working provides an income that can be used to meet physiological and safety needs, this presumes that an individual is able to collect themselves to a point where they can physically locate a workplace, interview for a job successfully, and then carry out the duties of the job in a satisfactory manner. If any of these things do not go according to plan, the individual is left in the undesirable condition of being without the safety and physiological necessities that money can buy. In addition to this, they may have given up assistances from the public sector that cannot be reinstated immediately, such as zero-cost housing and food assistance (Loveland, Driscoll, & Boyle, 2007). Thus, an individual with mental illness can go

through the troubles of attempting to obtain a job only to be left substantially worse off than when the ambition overtook them.

To an individual with mental illness, safety can sometimes be provided in the form of medication and psychotherapy to ward off their meddlesome thoughts and the physical manifestations of illness that often accompany them. Medications usually are not cheap, and psychotherapy is almost always expensive. Thus, the choice that individuals with mental illness often have to make is between a significantly impaired level of functioning and relying on social assistance programs. Surviving on government and charitable assistance requires efforts similar to those exerted in a full time job. Assistance schemes that are contingent on demonstrated personal effort might prod individuals without an illness toward employment, but the burden that they place on an individual with an illness can push them ever closer to episodes of severe depression, psychosis, or just a drastic decrease in functioning.

The fact that many individuals with mental illness cannot shake their safety needs for substantial amounts of time leaves them disadvantaged in other less apparent ways. For example, there may be no time to adjust to a neighborhood's social climate, practice interacting with acquaintances, or learn the skills that are used when employed. Adjustment and social skill both play large parts in whether one is able to hold a job. Every day spent primarily attempting to satisfy safety needs further handicaps many individuals in their social and economic capacities.

Safety needs are not only relevant to the individual with mental illness. While most forms of mental illness are nothing to fear, coworkers and managers frequently have preconceived notions about the "dangers" of working with the mentally ill. Since "normal" people usually make up the bulk of workers in competitive employment, the possible claim that

the safety needs of others should override a mentally ill individual's opportunity to work is a valid concern.

A proliferation of high-intensity hygiene factors.

If Wilkinson, Orth, and Benfari's (1986) connection between Maslow and Herzberg is accurate, an increased need for safety should translate into an increased number of elements that serve as hygiene factors in the workplace. Therefore, individuals with mental illness who get a job will be less likely to remain in that job than a "normal" employee because they must contend with more potentially absent hygiene factors. If these hygiene factors are indeed absent, job dissatisfaction may grow to a point at which it might override all of job satisfaction derived from content-based motivators. When this occurs, an individual usually leaves a job. There is no reason why this would not occur with individuals who are mentally ill.

While a lack of hygiene factors in the workplace makes a job onerous for individuals without mental illness, symptoms and stigma can combine to make individuals with mental illness even more uncomfortable. For example, Herzberg (1968) identifies "company policy and administration" as a hygiene factor. If an individual with mental illness is to take advantage of their right to accommodations under the Americans with Disabilities Act of 1990, they must engage in a dialogue with organizational administration about workplace policy. Individuals seeking accommodations will not always have a bad experience, but this extra layer of negotiation around a sensitive subject creates an opportunity for interpersonal friction that regular employees do not have to deal with. If an employee with mental illness forgoes their right to reasonable accommodations because they despise the bureaucratic red tape that encapsulates it, certain job conditions that could otherwise be mitigated can chip away at their mental wellbeing.

Herzberg (1968) also described workplace supervision as a hygiene factor. Intense scrutiny and micromanagement signal a lack of trust in an employee's competence or honesty, and thus would be objectionable to nearly all workers. When an employee with mental illness calls attention to the ways in which they differ from other workers through unusual behavior or a request for accommodations, organizational managers may intentionally or subconsciously increase their supervision of the employee in question. Mental illness is not the only factor that leads to increased attention from workplace superiors, but the highly personal nature of this topic could lead employees with mental illness to interpret additional scrutiny as an overt affront instead of a behavior based in a lack of understanding.

The types of jobs that individuals with mental illness often hold can exacerbate the sway that hygiene factors exert. The additional scrutiny previously referenced would be particularly hard to escape in entry level jobs in the services sector, such as fast-food preparation, cash register operation, and janitorial work. Similarly, low-level work in the services sector does not always pay well. Herzberg (1968) listed compensation as a hygiene factor, and deficiencies in this area will in turn lead to job dissatisfaction. As a result, workers with mental illness may find the jobs that are most available to them particularly unnerving and dissatisfying.

The painful structure of the low-level workplace.

The general structure of the workplace may be problematic for individuals with mental illness, particularly when they enter at very low positions. Lower-level positions are more likely to be managed in accordance with McGregor's Theory X philosophy than midlevel or executive positions. Employee discretion will be low, the opportunity for participative management will not be present, and it is entirely possible that the employees will be treated harshly by managers. The stereotypical image of an employee with mental illness is often that of someone who needs

constant direction to be kept on track even in relatively simple tasks, but this is frequently a misconception. As is the case with the general population, some individuals with mental illness do indeed prefer receiving directions as they carry out a task. However, many other individuals with mental illness have no such need for forced linearity and are just as capable of working without excessive direction as their self-directed peers in the general population. Theory X management will be based on the same underlying principles no matter what population it is applied to, and the illness or disability status of this population will not likely mitigate its general unpleasantness or cynicism.

It is commonly understood that mental illness can shift thought patterns into a mode in which vast discrepancies exist between reality and the mental construct of this reality that individuals with mental illness experience. However, one must ask what happens to the individual's thought paradigm once the symptoms of mental illness are removed or lessened. If what can be considered "white noise" is removed, it should leave behind a thought structure that is creative in ways that are not completely fathomable to the ordinary population. Thus, the constraint of an individual who has been or is currently coping with a mental illness to a Theory X management style could be unbearable. They could easily flourish in the Theory Y management systems that are in place for workers who the management esteems and where creativity is seen as a way to gain market share and command profits. If the individual can tolerate the job until they reach this point, they may be in a very good position. However, the consignment of an individual with mental illness to the lowest organizational levels simply because of their history or perceived functionality could easily turn out to be an extreme mismanagement of human capital that will leave neither the worker nor the organization better off.

Methodology

People in different positions will naturally have different perceptions of the same thing. If one wants to truly understand a phenomenon, it is therefore crucial to solicit the views of multiple people who relate to it in different ways. Understanding the needs of individuals with mental illness who do or do not desire to join the workforce requires direct interaction with this population. Additional insight can be gained through interaction with the people who assist these individuals with their mental health needs on a regular basis and have a developed relationship with them. Finally, information can be obtained from individuals who oversee the development of the relationships between staff and mental health consumers.

Approaching the issue of mental illness and employment from a perspective based in interaction with consumers and the agency staff that work with them is reminiscent of standpoint theory. It is only by focusing on the people at the center of an issue that one can gain a true understanding of it. Academics, psychologists and psychiatrists have professional opinions about employment and mental illness but they are often different from the sentiments of mental health consumers. A literature review was conducted to provide scholarly input on the studied phenomena, but the available material fell short of expectations. Unfortunately, neither consumers nor professionals have developed research instruments that suitably probe the interaction of mental illness and employment from a motivational perspective. This paucity of research instrument development by both groups in question led the primary researcher to construct a survey that was informed by the scholarly work of motivational theorists as presented in the literature review but designed for administration to mental health consumers. This strategy ultimately provided an opportunity to assess the applicability of motivational theories to this population through an examination of certain attitudes about employment.

However, it is also important to realize that the population of individuals with mental illness is not a homogenous group. Different diagnoses result in different symptoms, and one's ability to be employed varies in accordance with what symptoms they experience. Individuals also vary in the extent of their involvement with the mental health infrastructure. This project engaged three different groups of consumers that seek services from the Mental Health Association of the Southern Tier. The three groups that participated in this project are Beacon Center users, Advocacy clients, and Compeer participants.

In terms of life situations, Beacon center users are generally in the most precarious place out of the three consumer groups. Most are either temporarily or permanently homeless, lack financial stability, and do not have a secure source of food. Many also have dual diagnoses of mental illness and chemical addiction. Individuals interacting with the Advocacy department are slightly better situated than Beacon center users, but they are also face very difficult challenges. Legal, financial, medical, and subsistence problems often bring individuals into contact with the Advocacy department. MHAST Advocates are trained in assisting with all of these problems and will connect clients with other organizations if MHAST is unable to meet their needs. Compeer participants are usually quite well connected within the mental health infrastructure and are getting most if not all of their mental health needs met. The Compeer program pairs individuals with mental illness with friendship partners to combat loneliness and take advantage of the healing powers of human interaction. While participation in the Compeer program does not necessarily mean that one is on a rapid course to recovery, it is indicative that some type of support network is in place.

Data Collection

Surveys.

The survey used in this project was designed for self-administration but could also be read to participants if they indicated an interest in such assistance. It contained three sections and was generally completed by participants in 10 to 30 minutes. The first section of the survey focused on employment attitudes. Participants were presented with 23 statements about employment that were answered through the selection of one of five Likert-style answers ranging from "strongly agree" to "strongly disagree." The second section of the survey measured respondents' interest in fourteen occupational areas through the use of a simple three point Likert scale with answers consisting of "interested," "not sure," and "uninterested." A series of eight general demographics questions that precluded personal identification comprised the survey's final section. A copy of this survey is presented in Appendix B.

Survey participants were sought by the principal investigator at the Mental Health Association of the Southern Tier on Tuesday, March 24, 2009, and Thursday, March 26, 2009, between 11:00 AM and 3:00 PM. These times were selected because MHAST offers Advocacy walk-in hours between 12:00 PM and 2:00 PM on Tuesdays and Thursdays. On March 24, several Compeer program participants who were involved in telephone communication with MHAST were asked to complete the survey by telephone and five agreed to do so. These five surveys were administered over the telephone by the principal investigator. Seven Advocacy clients were surveyed by the principal investigator over the course of these two days. Surveys were also administered at MHAST's Beacon Center on March 27, 2009, between 5:00 PM and 7:30 PM. The Beacon Center provides food, shelter, and socialization opportunities to individuals who are experiencing homelessness, hunger, or loneliness on Fridays, Saturdays, and

Sundays. Eighteen Beacon Center clients participated in the survey on March 27, 2009. These three consumer groups were separated for data analysis purposes because they vary in their involvement with mental health services and general life situations.

Limitations.

The research methodology employed in this study has several significant limitations. The first notable limitation is the non-random administration of the survey. Since it was only administered to individuals seeking services from MHAST, it stands to reason that these individuals prefer the service they receive at this location to that of other community mental health providers. Populations served by these other providers may have answered many of the survey questions differently. Some social desirability bias was likely encountered since the principal researcher or an employee of MHAST was present, but not looking at answers, while the surveys were completed (Schutt, 2006). Trust, confidentiality, and time issues made personal interviews with consumers unfeasible. All individuals, including those with mental illness, would likely be hesitant to share extensive and somewhat personal information with an unfamiliar researcher. Limitations in the knowledge of the researcher made it impossible to develop a survey format that included all issues relevant to employment and mental illness.

An error in the construction of Section Two of the survey likely resulted in administration problems in some instances. Answer choices were inadvertently omitted on the fourth question of this section. Some respondents did place a mark in the blank space where the answer choices should have been, but it is unclear if other participants circled their answer to question four using the choices provided for question five. If this had been done, it is likely the respondent remained a line off in their responses for the remainder of this section. For the sake of preserving the

section for data analysis, the assumption was made that respondents who did not write in an answer for question four simply skipped it.

Data Analysis

Data correction and simplification.

Before the data collected with the survey could be analyzed, much of it had to be corrected. Many respondents gave more than one answer per question or had skipped questions. Instead of completely discarding all surveys that contained invalid information and reducing the sample size by approximately 30 percent, only the questions with invalid answers were excluded from the analysis process. To do this, invalid responses were simply left blank during data entry and then omitted from all data analysis procedures.

The principal investigator also decided to simplify the five-point Likert scale of Section One to a three-point Likert scale. This conversion was done so that statistical relationships would be strengthened during any subsequent analysis. Additionally, it allowed the subjective differences between the "strongly agree" and "agree" and the "disagree" and "strongly disagree" answer choices at both ends of the five-point Likert answer scale to be removed. All affirmative answers were converted to "agree" and all negative answers were converted to "disagree." After this alteration, answers expressing agreement were coded with the number "1", ambivalent answers were coded with the number "2", and answers expressing disagreement were coded with the number "3".

Confirming the non-randomness of responses.

One of the main concerns when administering a survey to subjects whose intellectual capacities may be compromised by illness, medication side effects, or both is whether the questions and answers were comprehended as the researcher intended. A logical extrapolation of

this concern is whether the recorded answers were generated from a true comprehension of the directions, the questions, and the supplied answers or if they were marked in a manner that was somewhat or completely random.

Chi-square tests were conducted to establish that the answers returned in Sections One and Two of the survey were not random. A separate chi-square test was conducted for each of the Advocacy, Beacon, and Compeer respondent groups using the simplified answers to Section One and then the unaltered answers to Section Two. To complete these six tests, chi-square was calculated by counting the actual number of each response for the section and group in question, determining the expected number of each response, and then substituting these numbers into the proper places in the chi-square test equation. The obtained value was then compared to p-values at various levels of significance with two degrees of freedom.

A correlation matrix that compared all possible question pairings was developed to test the construct validity of the survey both within and across the perceived boundaries of the motivational theories on which this project draws. Variable interrelation is essential to the establishment of construct validity (Salkind, 2007). The presence of pronounced correlations between questions based in the work of different motivational theorists would advance the often suggested but seldom developed (with the exception of Wilkinson, Orth and Benfari (1986)) idea that Herzberg, Maslow, and McGregor's ideas are excerpts from a single overarching theory.

Assessing comparability of client groups.

The Advocacy, Beacon, and Compeer respondent groups were initially treated as different populations in this project because they vary in the degree to which they receive mental health services and other forms of assistance. The determination of if these three groups are different in their employment-related attitudes and job preferences would be of great value to the

Mental Health Association of the Southern Tier in the later stages of program planning since it will determine if general services, such as workshops, need to be offered to these groups in different forms. If no appreciable differences are found, time and money can be saved by developing the cornerstone services of the employment program in a manner that meets the general needs of all three groups. If the three groups are indeed different, the developing program will need to find ways to address these variances.

In line with these concerns and considerations, analysis of variance tests were conducted on the Advocacy, Beacon, and Compeer groups' answers for the 23 questions in Section One and the 14 occupational categories in Section Two. F-values were computed using the "ANOVA: Single Factor" feature in Microsoft Excel 2007's Data Analysis ToolPak.

Assessing demographic characteristics.

The third and final statistical procedure that was used to analyze the results of the survey was a series of chi-square tests based on the demographics questions in Section Three. These tests were intended to check the "goodness-of-fit" between the answers given to the questions in Sections One and Two by participants from the different demographic groups as defined by the answer choices to each question in Section Three. If significant variation between groups was found in the previously described analyses of variance for a given question, a separate chi-square test would be done for each of the three surveyed samples for that question, resulting in 111 chi-square tests per question in Section Three. If no significant variation was found in the analysis of variance tests, the three surveyed samples would be processed as one group and 37 chi-square tests would need to be performed for each question in Section Three. All of the chi-square tests done in this third round of testing were calculated with Excel 2007's CHITEST function.

In order to conduct as many chi-square tests as possible, the data was collapsed into two categories for some of these questions. Four questions were reduced to two categories: 3-2 ("64 and under" and "65 and older"), 3-3 ("High school graduate or less" and "Some college or more"), 3-4 ("I have a job" and "I have no job") and 3-7 ("1-2 mental health services per month" and "3 or more mental health services per month").

Data analysis limitations.

While statistical analysis is possible when 30 cases are present, its quality is limited. The measurement of variables at the nominal or ordinal level, as they were in this project, also limits the statistical tests that can be performed. The analysis of variance testing found statistically significant variation between groups on questions 1A and 1L, but chi-square tests could not be performed for each of the three sample groups because some answer choices were not observed and thus left zeroes in the chi-square test setup. This problem also resulted in the loss of opportunity to perform some chi-square tests when all three sample groups were considered together.

Findings

When the results of the statistical tests are supplemented with simple descriptive statistics, four main findings emerge. Specifically, 1) survey participants responded in a deliberate and patterned manner that lends credence to the interrelatedness of the theories of Herzberg, Maslow, and McGregor; 2) Advocacy clients, Beacon users, and Compeer participants can largely be considered a single population in terms of employment attitudes and interests, with one major qualification; 3) Demographic traits do not appreciably alter employment attitudes and interests among the sampled populations; and 4) The majority of survey respondents perceive themselves as ready for some type of employment and want to work.

Finding One: Survey participants responded in a deliberate and patterned manner that lends credence to the interrelatedness of the theories of Herzberg, Maslow, and McGregor

The steps taken to test the non-randomness of responses soothed initial fears that the survey was too complex for the sample populations and provided evidence that the theoretical underpinnings of the project are sound. All six chi-square tests that were performed to determine the probability that participant responses were non-random in each section of the survey yielded values that were significant at the 0.01 level, as shown in Table 1.

Table 1

Chi-Square Values by Sample Group and Survey Section

	Advocacy Group	Beacon Group	Compeer Group
X^2 – Section 1	55.69**	133.09**	52.80**
X^2 – Section 2	16.41**	36.62**	80.32**

Note.$^{**}p<0.01$

The response patterns observed in Section One of the survey are generally in line with what Herzberg, Maslow, and McGregor assert to be true in their motivational theories. The presence of moderate to strong correlations between questions that span the work of these authors yet remain within the work motivation domain is perhaps indicative that a "complete" theory would, or could, account for all elements observed. Wilkinson, Orth, and Benfari (1986) showed how Herzberg's Motivation-Hygiene theory, Maslow's Theory of Human Motivation, and McGregor's Theory X and Theory Y related to each other, but they stopped short of advancing a theory of work motivation that was truly macroscopic. Such a theory cannot be proposed in a project of this magnitude, but the correlation coefficients that are presented in

Table 2 should give additional support to the notion that the ideas of these theorists do indeed intermingle.

Table 2

Selected Correlation Coefficients from Survey Section One

	A. I want to work.	D. Becoming competent at performing a task is important to me.	E. I experience an increased sense of satisfaction when I engage in productive activities.	P. Workers should be encouraged to think creatively.	T. I take factors other than money into consideration when making decisions regarding employment.
A. I want to work.	1.0000				
D. Becoming competent at performing a task is important to me.	0.5123	1.0000			
E. I experience an increased sense of satisfaction when I engage in productive activities.	0.6682	0.5145	1.0000		
P. Workers should be encouraged to think creatively.	0.6115	0.2588	0.8305	1.0000	
T. I take factors other than money into consideration when making decisions regarding employment.	0.7876	0.6503	0.7373	0.5330	1.0000

Note. Correlation Coefficients Based on Simplified Question Results.

Finding 2: Advocacy clients, Beacon users, and Compeer participants can largely be considered a single population in terms of employment attitudes and interests, with one major qualification

Analysis of variance tests were carried out for all questions in Sections One and Two of the survey, but F-values that were statistically significant at the 0.05 level were found for only two questions in Section One and zero questions in Section Two. An exhibit of the Section One questions and the F-value generated by the analysis of variance test performed on each one is shown in Table 3.

While the statistically significant F-values introduce a major qualification and will be discussed subsequently, the general lack of statistically significant variance in the employment-related attitudes and interests among Advocacy clients, Beacon users, and Compeer participants is most worthy of attention. These similarities suggest that employment-related attitudes and interests are probably not entirely a function of a consumer's involvement with mental health infrastructure or the intensity of the mental health services they receive. A short-sighted interpretation that must be avoided is the attribution of these attitudes and interests to what might appear to be the common denominator for all three groups: their status as individuals with mental illness. Instead, a more transcendent explanation is available in that all of these individuals are human and therefore share a natural drive toward productivity.

The qualification to the overarching statistical similarity in the attitudes and interests of these three MHAST consumer groups is that the two questions on which there is appreciable variance – "I want to work" and "I prefer to be closely supervised or watched when carrying out a task" – are quite important. In fact, the "I want to work" question addresses an overall mindset, not just an attitude. The source of the variance in both cases springs from the answers of the small Compeer sample group. Whereas the other two groups largely agreed with the

statement "I want to work," four out of the five Compeer respondents disagreed. In the case of the latter question, all four Compeer respondents who answered this question disagreed, but the other two sample groups contained some individuals who either had neutral feelings or agreed.

Mental illness is not likely to be comfortable in any situation, but the supports one has in place do a lot to make the situation at hand more bearable. When it was recommended to the primary researcher that the Advocacy, Beacon, and Compeer group results initially be tabulated separately, this was attributed to the fact that Compeer participants are quite well situated within the mental healthcare system, while the other two groups are notably less involved. Perhaps this high level of involvement has convinced many Compeer participants that they can get by emotionally, socially, and cognitively without work. It is also possible that Compeer participants have also received many more negative assessments of their ability to work by mental health professionals than the other two groups. When encouraged to respond to questions from the perspective of a worker, Compeer participants do not differ from the Advocacy and Beacon groups. However, gaining the desire to work is a first and important hurdle that needs to be overcome.

Table 3

Section One ANOVA F-Values

F-value	Questions – Section One	
7.40**	A.	I want to work.
0.05	B.	I believe that working improves one's mental health.
0.09	C.	I have skills that are useful in the workplace.
0.46	D.	Becoming competent at performing a task is important to me.
0.08	E.	I experience an increased sense of satisfaction when I engage in productive activities.
0.15	F.	The workplace is a good place to form friendships with individuals who share my interests.
0.24	G.	I like having frequent interactions with coworkers when working.
0.44	H.	I like having frequent interactions with my manager or boss when working.
1.68	I.	I like having frequent interactions with professionals from other organizations when working.
0.83	J.	I like having frequent interactions with the public when working.
0.27	K.	I would prefer to have limited interactions with other people when working.
3.74**	L.	I prefer to be closely supervised or watched when carrying out a task.
1.95	M.	I prefer to be given instructions or told what to do when someone wants me to complete a task.
0.52	N.	Workers and management should act as a team when deciding what jobs need to be done.
1.40	O.	Workers should be able to give input on how a job is to be completed.
0.12	P.	Workers should be encouraged to think creatively.
0.70	Q.	Earning an income is the most important reason for working.
0.40	R.	I would not want to work if I had enough money to meet all of my expenses.
1.47	S.	Receiving recognition is more rewarding than receiving money when I do something well.
1.26	T.	I take factors other than money into consideration when making decisions regarding employment.
1.72	U.	I feel overwhelmed when I think about finding a job or going to work.
1.31	V.	I would use an employment-assistance service to get a job or advance my career.
1.34	W.	Employers have not always been receptive to my life situations or medical diagnoses when I have sought employment in the past.

Note. Possible responses to all questions in Section One were "strongly agree/agree," "neutral feelings," and "disagree/strongly disagree" (after simplification by principal researcher).

**$p<0.05$

Finding 3: Demographic traits do not appreciably alter employment attitudes and interests among the sampled populations

The chi-square tests that were carried out to assess demographic characteristics returned critical values that did not achieve statistical significance in any testable instance in Sections One and Two. This is an indication that the frequency of answers to all testable questions in Sections One and Two are equal across the demographic categories within each question in Section Three of the survey. This makes sense if employment attitudes and interests are a function of an individual's humanity instead of their gender, amount of schooling, age, or other characteristics that do not fundamentally change the essence of one's relation to the world of work.

On the other hand, it is somewhat surprising to see that certain stereotypes did not manifest themselves in the results. People who fall into certain demographic categories are often encouraged by society to think a certain way and have certain interests. At this point, it is not possible to conclude that demographic traits are irrelevant in the response patterns to all survey questions because some of the data was not amenable to testing with chi-squares. Other nonparametric tests might be able to process the answer sets which had zeroes in some cells during the setup of the chi-square tests and return results that either perpetuate or refute the observed trend of demographic traits not influencing employment attitudes or interests.

Finding 4: The majority of survey respondents perceive themselves as ready for some type of employment and want to work

Simple frequency counts for answers to certain questions in Sections One and Two reveal that the majority of survey's respondents want to work, believe they have skills that are useful in the workplace, and would use an employment services program to prepare for a job. In terms of occupational interests, a majority of respondents are interested in a helping profession or

volunteering. These results are shown in Tables 4 and 5. The results to these questions provide evidence that it is not consumers' attitudes about employment or their abilities that are holding them back, but rather matters related to the availability of employment or the process of obtaining it. Therefore, MHAST does not have to primarily concentrate on changing consumers' attitudes about employment but instead needs to help connect them with job opportunities.

Table 4

Selected Questions and Answers from Survey Section One

	A. I want to work.	C.I have skills that are useful in the workplace.	V. I would use an employment-assistance service to get a job or advance my career.
Strongly Agree/Agree	19	18	17
Neutral Feelings	3	4	7
Disagree/Strongly Disagree	6	8	4

Note. All numbers indicate frequency of usable responses given for each respective question and answer choice.

Table 5

Selected Careers and Interest Levels from Survey Section Two

	c. Doctor, nurse, hospital orderly, laboratory technician, social worker, counselor, etc.	n. Volunteering
Interested	14	16
Not Sure	4	4
Uninterested	8	2

Note. All numbers indicate frequency of usable responses given for each respective question and answer choice.

While these findings are encouraging, it is not realistic to expect all consumers who desire a job to obtain one if MHAST simply provides a connection to an employer. However,

these human resources can be of substantial use to the organization as the MHAST employment services program is developed and beyond. Bringing the consumers who are ready to work, have skills, and are interested in helping professions or volunteering into a closer relationship with the organization has the potential to directly benefit these consumers, other consumers who may not be as prepared for employment, and MHAST as a whole.

Recommendations:

The Mental Health Association of the Southern Tier is trusted by consumers to deliver programming and services that will help them improve the quality of their lives. Developing an employment services program is a logical way for the organization to increase its ability to bring change to the lives of individuals with mental illness in the local area.

The findings of this study directly support three main recommendations for the future operation of the Mental Health Association of the Southern Tier and any employment services program it might develop. Implementing these recommendations can make the prospective employment services program as capable as possible at minimum cost. They also offer a way to build even better relationships with consumers who are eager to volunteer.

Recommendation 1: The developing employment services program should be based in MHAST's Advocacy Department

Although Advocacy clients, Beacon users, and Compeer participants are very similar in their employment attitudes and interests despite their differing amount of involvement with the mental healthcare system, it is recognized that the levels of assistance that these groups will require to make employment a reality will vary. MHAST Advocates are trained to help consumers in all life areas where difficulties are being experienced, such as obtaining basic necessities like food and housing, dealing with legal problems, and gaining access to appropriate

healthcare and medications. If the employment services program is centered in the Advocacy Department, the additional training that employees need will be limited to employment-related areas. This approach is also preferable because it will allow consumers who are receiving services to work with a single MHAST employee across a wide variety of issues.

Of course, there is the possibility that the use of employment experts would result in a program that is able to connect more consumers with employment and do so in a shorter amount of time. Such an outcome would be desirable from the perspective of both the agency and consumers. However, MHAST does not have any employees who fit this description on hand and hiring them would require a substantial monetary outlay. In addition to this, such employees would likely lack experience in the operation of a mental health agency and would need significant training before they could assist in other agency tasks. Therefore, cost and functionality issues make the hiring of employment professionals much less feasible than training current Advocates in employment-related areas.

By planning a program that is originally limited in scope and locating it within the Advocacy Department, MHAST can avoid the expense of creating a new department to implement the program. If the employment services program grows to the point that MHAST needs to hire an additional employee or employees to assist with it, the money would be best spent in hiring Advocates instead of employment specialists because the former group can render a more diverse array of services.

Recommendation 2: Develop employment services program resources for use across consumer subpopulations and demographic groups

Given the general similarities of Advocacy clients, Beacon users, and Compeer participants in employment attitudes and interests and the lack of association between

demographic category and these same factors, resources for the employment services program should be developed in a manner that allows for application and use across consumer subpopulations. Instructional materials about basic aspects of employment like professional etiquette, job search and interview strategies, workplace interactions, and disability-related accommodations should be developed for presentation in staff-run workshops and standalone print publications. If Advocates feel that consumers seeking direct assistance with employment are not appropriately prepared, access to such assistance could be made contingent upon completion of certain "pre-employment" requirements, such as attendance at a minimum number of competency-based workshops.

Recommendation 3: Formalize relationships with the substantial number of consumers interested in volunteering

As noted in Finding 4, survey respondents generally consider themselves ready to work and many are interested in volunteering. Part of the employment services program creation process should be dedicated to providing consumers who are interested in volunteering with opportunities to get involved with MHAST and its work. Ideally, consumers who consider themselves skilled in tasks that are in demand in the workplace would be provided with the opportunity to teach these skills to other consumers. If this was accomplished, at least three parties would benefit: the consumers who want to volunteer, consumers who want to advance their employability, and the Mental Health Association of the Southern Tier at the human resources level.

Conclusion

As this project has shown, the employment attitudes of many individuals with mental illness can be explained through the general motivational theories of Herzberg, Maslow, and

McGregor. The fact that the general population and the population of individuals with mental illness have virtually the same feelings about employment may surprise those who see no way to correct the vast discrepancies in employment rates between these two groups. However, the perception of difference is often all that it takes to create strikingly discordant social outcomes.

Therefore, the crafting of programs designed to restore employment opportunities to individuals who have done nothing to intentionally scuttle them is an example of public management at its best. The active promotion of equity in employment has the potential to be the first step toward a future where all capable people are afforded the opportunity to work. At a minimum, the results of this study should remind the general public that individuals with mental illness are largely willing to work. While connecting this group with job opportunities will still take substantial effort, it is an endeavor that will benefit all involved.

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Appendix A

BINGHAMTON
UNIVERSITY
STATE UNIVERSITY OF NEW YORK

Human Subjects Research Review Committee
PO Box 6000
Binghamton, New York 13902-6000
607-777-3818, Fax: 607-777-5025

Date: June 5, 2008

To: John Pelowski, DPA

From: Raymond G. Romanczyk, Chair
Human Subjects Research Review Committee

Subject: Human Subjects Research Approval
Protocol Number: 873-08
Protocol title: *Mental Health Needs and Employment*

Your project identified above was reviewed by the Human Subjects Research Review Committee (HSRRC) at a convened meeting on **June 5, 2008** and has been approved pursuant to the Department of Health and Human Services (DHHS) regulations, 45 CFR Part 46 section 111.

You will be required to submit a Continuing Review application annually as outlined by Federal Guidelines: *46.109 (e) An IRB shall conduct continuing review of research covered by this policy at intervals appropriate to the degree of risk, but not less than once per year, and shall have authority to observe or have a third party observe the consent process and the research.*

If your project undergoes any changes or modifications these changes must be reported to our office prior to implementation.

Any unanticipated problems and/or complaints related to your use of human subjects in this project must be reported, using the form listed below, http://humansubjects.binghamton.edu/Forms/Forms/Adverse%20Event%20Form.rtf and delivered to the Human Subjects Research Review Office within five days. This is required so that the HSRRC can institute or update protective measures for human subjects as may be necessary. In addition, under the University's Assurance with the U.S. Department of Health and Human Services, Binghamton University must report certain events to the federal government. These reportable events include deaths, injuries, adverse reactions or unforeseen risks to human subjects. These reports must be made regardless of the source of funding or exempt status of your project.

University policy requires you to maintain as a part of your records, any documents pertaining to the use of human subjects in your research. This includes any information or materials conveyed to, and received from, the subjects, as well as any executed consent forms, data and analysis results. These records must be maintained for at least six years after project completion or termination. If this is a funded project, you should be aware that these records are subject to inspection and review by authorized representative of the University, State and Federal governments.

Please notify this office when your project is complete by completing and forwarding to our office the following form: http://humansubjects.binghamton.edu/Forms/Forms/Protocol%20Closure%20Form.rtf
Upon notification we will close the above referenced file. Any reactivation of the project will require a new application.

Thank you for your cooperation, I wish you success in your research, and please do not hesitate to contact our office if you have any questions or require further assistance.

cc: file
Allison Alden

Bulizak, Diane

From: Bulizak, Diane
Sent: Thursday, March 19, 2009 1:22 PM
To: 'jpelows1@binghamton.edu'
Cc: Campbell, David
Subject: Human Subjects Modification Approval

Date: March 19, 2009

To: John Pelowski, DPA

From: Anne M. Casella, CIP Administrator
Human Subjects Research Review Committee

Subject: Modification Approval
Protocol Number: 873-08
Protocol title: *Mental Health Needs and Employment*

Your project identified above was reviewed by the HSRRC and your modification which consist of a title change and has received an expedited approval and still meets the requirements pursuant to the Department of Health and Human Service 45 CFR 46.111and 45 CFR 46.110(b)(2) .

The modification includes the use of a new survey to solicit data from MHAST clients and interview schedule will guide interviews of employees of MHAST's Advocacy Department. Faculty supervisor is changed from Dr. Allison Alden to Dr. David Campbell.

If your project undergoes any other changes, these changes must be reported to our office prior to implementation.

Please notify this office when your project is complete by completing and forwarding to our office the following form:
http://humansubjects.binghamton.edu/Forms/Forms/Protocol%20Closure%20Form.rtf
Upon notification we will close the above referenced file. Any reactivation of the project will require a new application.

This documentation is being provided to you via email. A hard copy will not be mailed unless you request us to do so.

cc: file

Diane Bulizak, Secretary
Human Subjects Research Review Office
Biotechnology Building, Room 2205
85 Murray Hill Rd.
Vestal, NY 13850
dbulizak@binghamton.edu
Telephone: (607) 777-3818
Fax: (607) 777-5025

Appendix B

Survey Instrument

Dear MHAST Client,

You are invited to participate in a research study of employment sentiments and desires among individuals who receive services from the Mental Health Association of the Southern Tier. I hope to learn about the types of jobs desired by MHAST clients and their general feelings on certain employment factors. You are being asked to participate in this study because you have sought assistance from the Mental Health Association of the Southern Tier.

If you decide to participate in the project, please complete the attached survey and place it in the large envelope designated by the MHAST employee assisting you. All MHAST employees have been asked to not look inside this envelope and I will be the only one opening it in order to retrieve the contents. Please do not place any identifying marks on the survey. No attempt will be made to connect any survey with any individual and your identity will remain anonymous. Upon your request, a MHAST advocate can read the survey to you. They will use a separate copy so that they will not see your answers as you record them. If you have any questions about this research, please call Amy Humphrey at (607) 771 8888 or Dr. David Campbell at (607) 777 9181.

Your decision whether or not to participate will not prejudice your future relations with Binghamton University or the Mental Health Association of the Southern Tier. If you decide to participate, you are not obligated to answer all questions, and may stop at any time.

Questions about your rights as a volunteer in research can be directed to Binghamton University's Human Subjects Research Review Committee at (607) 777-3818.

Your voluntary completion of the survey constitutes consent to participate. Thank you for assisting me with this study.

Sincerely,
John Pelowski
PAFF 595 Student
Binghamton University

Thank you for agreeing to participate in this employment survey. Please answer the following questions to the best of your ability. The information collected in the "Respondent Demographics" section is for statistical purposes only. No attempt will be made to identify any individuals taking part in this survey. Please do not write your name or any unsolicited information on this survey. When finished, please place this survey in the large envelope indicated by the employee assisting you.

1. Please rate your agreement with the following job-related statements by circling one answer for lettered statement.

Strongly Agree	Agree	Neutral Feelings	Disagree	Strongly Disagree		
1	2	3	4	5	A.	I want to work.
1	2	3	4	5	B.	I believe that working improves one's mental health.
1	2	3	4	5	C.	I have skills that are useful in the workplace.
1	2	3	4	5	D.	Becoming competent at performing a task is important to me.
1	2	3	4	5	E.	I experience an increased sense of satisfaction when I engage in productive activities.
1	2	3	4	5	F.	The workplace is a good place to form friendships with individuals who share my interests.
1	2	3	4	5	G.	I like having frequent interactions with coworkers when working.
1	2	3	4	5	H.	I like having frequent interactions with my manager or boss when working.
1	2	3	4	5	I.	I like having frequent interactions with professionals from other organizations when working.
1	2	3	4	5	J.	I like having frequent interactions with the public when working.
1	2	3	4	5	K.	I would prefer to have limited interactions with other people when working.
1	2	3	4	5	L.	I prefer to be closely supervised or watched when carrying out a task.
1	2	3	4	5	M.	I prefer to be given instructions or told what to do when someone wants me to complete a task.
1	2	3	4	5	N.	Workers and management should act as a team when deciding what jobs need to be done.
1	2	3	4	5	O.	Workers should be able to give input on how a job is to be completed.
1	2	3	4	5	P.	Workers should be encouraged to think creatively.
1	2	3	4	5	Q.	Earning an income is the most important reason for working.
1	2	3	4	5	R.	I would not want to work if I had enough money to meet all of my expenses.
1	2	3	4	5	S.	Receiving recognition is more rewarding than receiving money when I do something well.
1	2	3	4	5	T.	I take factors other than money into consideration when making decisions regarding employment.
1	2	3	4	5	U.	I feel overwhelmed when I think about finding a job or going to work.
1	2	3	4	5	V.	I would use an employment-assistance service to get a job or advance my career.
1	2	3	4	5	W.	Employers have not always been receptive to my life situations or medical diagnoses when I have sought employment in the past.

Please continue the survey on the next page→

2. Please indicate your interest in the following occupational areas by circling one answer for each lettered line:

Interested	Not Sure	Uninterested		
1	2	3	a.	Construction, carpentry, welding, vehicle repair, etc.
1	2	3	b.	Cook, bartender, hotel worker, etc.
1	2	3	c.	Doctor, nurse, hospital orderly, laboratory technician, social worker, counselor, etc.
			d.	Teacher, teacher's aide, guidance counselor, school librarian, etc.
1	2	3	e.	Government and law careers
1	2	3	f.	Accountant, loan arranger, bank teller, etc.
1	2	3	g.	Secretary, clerk, bookkeeper, etc.
1	2	3	h.	Cashier, salesperson, stocker, etc.
1	2	3	i.	Artist, musician, photographer, writer, etc.
1	2	3	j.	Computer programmer, multimedia developer, web developer, database manager, computer support services, etc.
1	2	3	k.	Mechanical engineer, electrical engineer, civil engineer, chemical engineer, etc.
1	2	3	l.	Assemblyperson in factory, machine operator, etc.
1	2	3	m.	Manager, administrator, organizational executive, etc.
1	2	3	n.	Volunteering

Please circle one answer for each of the following demographic questions:

1. What is your gender?
   a. Male
   b. Female

2. In what age group do you fall?
   a. 25 years or younger
   b. 26 years to 64 years
   c. 65 years or older

3. What is the best description of your level of education?
   a. Some grade high school
   b. High school graduate or GED certificate
   c. Some college
   d. Bachelor's degree
   e. Graduate degree or higher

Please continue the survey on the next page→

4. What statement best describes your current employment status?
   a. I have a job that I enjoy.
   b. I have a job that I do not enjoy.
   c. I do not have a job but I want to work.
   d. I do not have a job and I do not want one.

5. What statement best describes your employment preference?
   a. I prefer full-time work.
   b. I prefer part-time work.
   c. I do not have a preference.

6. Is transportation an issue in your decision to work or not work?
   a. Yes
   b. No

7. Approximately how many times each month do you receive mental health services from the Mental Health Association of the Southern Tier or any other provider?
   a. 1 to 2
   b. 3 to 5
   c. 6 to 10
   d. 11 to 15
   e. 16 or more

8. Do you receive government assistance (food stamps, Social Security, welfare, etc.) of any kind?
   a. Yes
   b. No

Appendix C

Survey Results

Table 6

Aggregate Results of Survey Section One

	Advocacy			Beacon			Compeer		
Question	Strongly Agree/ Agree	Neutral Feelings	Disagree/ Strongly Disagree	Strongly Agree/ Agree	Neutral Feelings	Disagree/ Strongly Disagree	Strongly Agree/ Agree	Neutral Feelings	Disagree/ Strongly Disagree
1A	5	1	1	13	2	1	1	0	4
1B	6	0	1	13	3	1	4	1	0
1C	4	2	1	11	2	5	3	0	2
1D	5	0	2	13	2	1	4	0	1
1E	5	1	1	12	3	1	4	0	1
1F	6	0	1	11	4	2	4	0	1
1G	5	1	1	13	2	1	3	2	0
1H	3	3	1	12	3	2	3	1	1
1I	4	1	2	9	6	1	5	0	0
1J	4	2	1	10	3	2	2	1	2
1K	2	2	3	5	8	3	2	1	2
1L	0	2	5	3	8	6	0	0	4
1M	3	1	3	8	5	4	4	0	0
1N	6	0	1	13	1	3	4	0	0
1O	6	0	1	15	0	0	4	0	0
1P	6	0	1	13	2	2	2	2	0
1Q	3	2	2	5	6	6	3	0	1
1R	3	2	2	5	4	7	2	1	1
1S	3	3	1	10	5	2	1	1	2
1T	6	0	1	13	2	2	2	0	2
1U	3	2	2	8	4	5	4	0	0
1V	4	1	2	9	6	2	4	0	0
1W	6	1	0	8	7	2	3	0	1

Note. All numbers indicate frequency of usable responses given for each respective question and answer choice.

Table 7

Aggregate Results of Survey Section Two

	Advocacy			Beacon			Compeer		
Question	Interested	Not Sure	Uninterested	Interested	Not Sure	Uninterested	Interested	Neutral Feelings	Uninterested
2a	3	2	2	7	1	7	0	0	4
2b	2	3	2	6	4	5	1	1	2
2c	4	1	2	8	2	5	2	1	1
2d	1	1	4	3	0	0	0	1	3
2e	1	0	6	5	3	7	2	0	2
2f	0	1	6	3	2	10	2	0	2
2g	1	2	4	3	0	11	3	0	1
2h	3	1	3	4	2	9	2	0	2
2i	1	2	4	10	0	5	1	1	2
2j	2	0	5	4	1	9	0	1	3
2k	1	1	5	7	1	7	0	0	4
2l	2	1	4	4	3	8	0	0	4
2m	2	2	3	4	4	7	1	1	2
2n	2	4	1	11	3	1	3	1	0

Note. All numbers indicate frequency of usable responses given for each respective question and answer choice.

Table 8

Aggregate Results of Survey: Section Three

	Advocacy					Beacon					Compeer				
Question	A	B	C	D	E	A	B	C	D	E	A	B	C	D	E
1	6	1	-	-	-	11	6	-	-	-	1	3	-	-	-
2	0	7	0	-	-	0	15	2	-	-	0	3	1	-	-
3	3	3	0	1	0	3	3	8	0	0	0	0	4	0	0
4	1	0	6	0	-	5	1	11	0	-	0	0	2	2	-
5	5	2	0	-	-	4	9	4	-	-	0	2	2	-	-
6	3	4	-	-	-	10	7	-	-	-	3	1	-	-	-
7	5	0	1	0	0	10	0	3	1	1	3	0	0	0	0
8	6	1	-	-	-	14	3	-	-	-	2	0	-	-	-

Note. All numbers indicate frequency of usable responses given for each respective question and answer choice. Dash indicates no answer choice for corresponding letter.